Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dr. Fredrick Kersh

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-11-4192-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 19, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The service performed was an Impairment Rating based on ROM & DRE This is reimbursed $300 ROM $150 DRE 2 BODY AREAS AND $138.56 for V4 office visit."

Amount in Dispute: $285.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement received however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2010	99455	$285.15	$271.59

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the medical fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired
   - 45 – Charges exceed your contracted/legislated fee arrangement
   - W1 – Workers Compensation state fee schedule adjustment

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Did the requestor support additional reimbursement is due?
3. Was the claim submitted timely with applicable codes and modifiers?

4. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on July 21, 2011. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
2. The carrier denied/reduced the disputed services as 45 – "Charges exceed your contracted/legislated fee arrangement." Review of the available information found no evidence that a contract existed between the two parties. The disputed services will be reviewed per applicable rules and fee guidelines.
3. Per 28 Texas Administrative Code §134.204. (j) states in pertinent part, "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR…". The requestor states, "Impairment Rating based on ROM & DRE…" Review of the document titled, "Impairment Rating" and "Figure 1. Upper Extremity Impairment Evaluation Record – Part 2" supports the services as submitted by the provider.
4. Per 28 Texas Administrative Code §134.204(j)(3) "The following applies for billing and reimbursement of an MMI evaluation. (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. (i) Reimbursement shall be the applicable established patient office visit level associated with the examination. (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit." Review of the medical claim finds the provider used the appropriate code and modifier and submitted the claim in a timely manner as a reconsideration was submitted October 15, 2010.

5. Per 28 Texas Administrative Code §134.204(j)(4)(A) and (C) states in pertinent parts, "The following applies for billing and reimbursement of an IR evaluation. (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas (ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area. (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR." The submitted medical bill show "2" body areas in the units column of the billing form however, only one area "shoulder" is on the submitted documentation. Therefore, only one unit will be considered with this review.

6. Per 28 Texas Administrative Code §134.204 (i)(2) When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section. (k) "…the reimbursement shall be $500 in accordance with subsection (i)." The calculation of the total MAR is as follows; 99455 V4 = ($500 x 25% = $125) $125 + 300 (IR musculoskeletal with ROM) + $150 (DRE evaluation of shoulder) = $575.00. The Carrier previously paid $303.41. The remaining balance is $271.59. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $271.59.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $271.59 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.